No. 02-469

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IN THE

# Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,
*Petitioner*,

v.

KENNETH L. NORD,
*Respondent*.

**On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit**

## BRIEF FOR THE CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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## INTEREST OF CENTRAL STATES

Central States is an "employee welfare benefit plan," and "employee benefit plan," and a "multiemployer plan" within the meaning of Sections 3(1), 3(3), and 3(37)(A) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1002(1), 1002(3), and 1002(37)(A).[1] It is administered by a ten person board of

[1] Pursuant to Rule 37.6, Central States represents that this brief has been authored solely by counsel for Central States and that no party other than Central States has made a monetary contribution for the preparation or submission of this brief.

trustees comprised of five employer trustees and five union trustees as required by Section 302(c)(5) of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 186(c)(5). Central States provides health benefits to approximately 100,000 active participants and 25,000 retirees. Pursuant to its trust agreement and plan, Central States provides various disability benefits to participants in the event a participant is disabled. Central States' trust agreement and plan give the board of trustees full discretionary authority to make benefit decisions including decisions concerning disability benefits. As a result of this discretionary authority, courts apply the arbitrary and capricious standard of review to benefit decisions made by Central States. *See, e.g., Exbom v. Central States, S.E. & S.W. Areas Health & Welfare Fund*, 900 F.2d 1138, 1141-42 (7th Cir. 1990).

As a multiemployer plan, the terms of the trust agreement and plan were initially created as the result of negotiations between various management associations and the International Brotherhood of Teamsters. The trust agreement and plan may be amended from time to time by the board of trustees that, as previously noted, has an equal number of representatives from employers and the union. As a result, the terms of the trust agreement and plan are the result of a balancing between the interests of employers and the union. Part of this balance is that the board of trustees is given discretionary and final authority to make decisions on benefit claims.

The decision below threatens to shift discretion away from plans to the participant via deference to the participant's treating physician. Recognition of a treating physician rule, while unwarranted in respect to benefit decisions of *any* ERISA plan is particularly inappropriate when a multiemployer plan is involved. The terms of the trust agreement and plan are part of a carefully negotiated balance.



In determining where the appropriate balance lies, both the employers and the union have relied on the fact that it is the decision of the board of trustees, not the participant's treating physician, which will be given deference. Because the employers and the union have premised their agreement on the appropriate terms of the plan on the board of trustees' discretion, allowing the views of the participant's treating physician to hold sway would result in the plan paying more benefit claims than anticipated at the time the plan computes the amount of contributions necessary by participating employers to fund the benefits. As a result, because a multiemployer plan depends on contributions from employers to survive, the plan will either need to cut benefits or increase contributions to make up for the increase in granted benefit claims. Either way, settled expectations are upset by the application of a rule that, as will be shown below, is entirely inappropriate in the ERISA context.

## SUMMARY OF ARGUMENT

The Ninth Circuit's holding that the treating physician rule applies in the ERISA context is incorrect. Unlike the Social Security Act and its accompanying regulations, ERISA and its accompanying regulations do not incorporate the treating physician rule. Indeed, an examination of ERISA and its regulations reveals that it would be contrary to ERISA and its regulations to recognize such a rule. The treating physician rule relies upon assumptions of bias by either the plan administrator or the consulting physicians hired by the plan (as well as an assumption of the lack of bias of a treating physician) that are unwarranted and directly contrary to the discretion afforded to plan administrators. Use of the treating physician rule is particularly inappropriate when a multiemployer plan is involved because the terms of such a plan, and the discretion afforded to the plan administrator, are the result of carefully negotiated compromises between the employers that participate in the plan and the union.

Furthermore, the equal representation of employers and union on the board of trustees of a multiemployer plan make any inference of bias unwarranted. For these reasons, this Court should hold that the Ninth Circuit erred in applying the treating physician rule in the ERISA context.

## ARGUMENT

The Social Security Act ("SSA") contains a provision that states that the Commissioner of Social Security shall "make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make . . . a determination [regarding disability], prior to evaluating medical evidence obtained from any other source on a consultative basis." 42 U.S.C. § 423(d)(5)(B). A regulation promulgated under the SSA provides that the "treating physician's opinion is entitled to controlling weight if it is well supported by medical findings and not inconsistent with other substantial evidence in the record." *Dixon v. Massanari*, 270 F.3d 1171, 1177 (7th Cir. 2001); 20 C.F.R. § 404.1527(d)(2). Thus, both the text of the SSA and the regulations provide a basis for the use of the treating physician rule in the social security context.

In contrast, ERISA has no statutory or regulatory basis for the use of the treating physician rule. Instead, an examination of ERISA and its regulations leads to the conclusion that application of the treating physician rule in the ERISA context is unwarranted. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court held that ERISA benefit determinations are to be reviewed by a court *de novo* "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. The rationale of this Court's holding in *Firestone* was that the interpretation of ERISA was to be guided by principles of trust law, and trust law principles indicate that deferential review is appropriate



when a trustee exercises discretionary powers. Based on this holding and rationale, the lower courts have held that the arbitrary and capricious standard of review applies to plans such as Central States that grant such discretion. *See, e.g., Exbom v. Central States, S.E. & S.W. Areas Health & Welfare Fund*, 900 F.2d 1138, 1141-43 (7th Cir. 1990). Thus, under ERISA, it is the decision of the plan administrator, not the treating physician, which is entitled to deference. As the Fifth Circuit has held in refusing to apply the treating physician rule, application of the treating physician rule requires giving deference to the treating physician's opinion which "would vitiate the discretionary authority expressly granted to [the trustees] in the contract." *Dowden v. Blue Cross & Blue Shield of Tex., Inc.*, 126 F.3d 641, 644 (5th Cir. 1997). To import the treating physician rule from the SSA to the ERISA context is inconsistent with the trust law principles that guide the interpretation of ERISA.

The use of the treating physician rule is based in large part upon the belief that disability benefits are salary replacement and therefore the treating physician in the disability context will tend to not be biased whereas the use of consulting physicians by plans is subject to bias. *See, e.g., Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1143 (9th Cir. 2001). However, the belief that a treating physician in the disability context will be unbiased is an unwarranted assumption. Many courts have noted in the health benefit context that such an assumption is unwarranted because the treating physician has an economic interest in the outcome. *See, e.g., Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992); *Jett v. Blue Cross & Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989). There may be many cases in which a participant will use disability benefits to pay for the future medical and rehabilitative services the participant needs, including

payments to the same treating physician who is supposedly unbiased. Further, as the Seventh Circuit has stated:

> We must keep in mind the biases that a treating physician may bring to the disability evaluation. "The patient's regular physician may want to do a favor for a friend and client, and so the treating physician may too quickly find disability." Additionally, we have noted that the claimant's regular physician may not appreciate how her patient's case compares to other similar cases, and therefore that a consulting physician's opinion might have the advantages of both impartiality and expertise.

*Dixon*, 270 F.3d at 1177 (internal citation omitted).

Second, the presumption that either the consulting physician or the plan administrator will be biased is incorrect both as a factual matter and because the presumption conflicts with ERISA. As this Court has recognized, ERISA specifically contemplates that fiduciaries of a plan may also be corporate officers. *Pegram v. Herdich*, 530 U.S. 211, 225 (2000). Additionally, the impact on the plan of granting or denying a particular claim will not be sufficiently significant as to threaten the plan administrator's impartiality. *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995). As a result, a court should not presume that bias exists and a mere showing of a potential conflict of interest is not enough to overcome the presumption of impartiality. *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998).

Further, the ERISA claim regulations specifically contemplate that plans will use consulting physicians. For example, the regulations provide that:

> [I]n deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary



> or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

29 C.F.R. § 2560.503-1(h)(3)(iii). In addition, the regulations provide that "the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual." 29 C.F.R. § 2560.503-1(h)(3)(v). The regulations quoted above also apply to disability benefit determinations. 29 C.F.R. § 2560.503-1(h)(4). These detailed regulations specifically contemplate the use of consulting physicians and provide safeguards for their impartiality. As a result, it would be unwarranted to presume that a consulting physician would be biased. Similarly, it would be unwarranted to presume that deference is to be given to the treating physician when no such deference is indicated in either the statute or the regulations. In rejecting the application of the treating physician rule to the veterans' benefit context, the Federal Circuit stated the following that is equally applicable to the ERISA context:

> Thus, unlike the Social Security benefit statutes, the VA benefits statutes and regulations do not provide any basis for the "treating physician" rule and, in fact, appear to conflict with such a rule. Moreover, given the comprehensive statutory and regulatory scheme for the award of veterans' benefits, it would not be appropriate for this court to impose the "treating physician" rule on the VA.

*White v. Principi*, 243 F.3d 1378, 1381 (Fed. Cir. 2001). ERISA and its regulations provide detailed rules for benefit plans to follow regarding the handling of claims. Nowhere in the statute or the regulations is the treating physician rule

mentioned and the assumptions underlying the rule are in fact contradicted by ERISA and its regulations.

Furthermore, there is even more reason to reject the use of the treating physician rule in the multiemployer plan context. The terms of a multiemployer plan reflect a delicate balance between the interests of the employers that participate in the plan and the union. *See Cozzie v. Metropolitan Life Ins. Co.*, 140 F.3d 1104, 1108 (7th Cir. 1998) (noting this fact with respect to a single employer plan created as the result of negotiations between a single employer and a union). When agreeing to the terms of the plan, the parties have expectations concerning how the plan will operate, including the discretion afforded to the plan sponsor. The carefully constructed benefits provided under the plan are agreed to by both the employers and the union with the understanding that the plan administrator will exercise the discretion conferred by the plan in a neutral fashion. Because the board of trustees (the plan administrator) consists of both employer and union representatives, "there is no conflict of interest to justify less deferential review." *Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480, 481 (9th Cir. 1990).

In the case below, the Ninth Circuit stated that because the treating physicians in this case disagreed with the consulting physician, "the plan administrator can reject the conclusions of the treating physicians only if the administrator gives specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002). Stated as a general matter, the requirement that the plan administrator have specific reasons for the benefit determination that are supported by substantial evidence is a well-settled issue. However, the Ninth Circuit has gone beyond this principal in stating that the treating physician rule "require[s] plan administrators to give *special weight* to the opinions of the treating physicians." *Regula*, 266 F.3d at 1144. Further, the



Ninth Circuit also couches the analysis in terms of a conflict of interest stating that a conflict of interest exists when there is an "insufficiency of those reasons" given by the plan administrator for denying a claim. *Nord*, 296 F.3d at 829.

An example highlights the flaw in the Ninth Circuit's use of the treating physician rule to eliminate the deference given to a plan administrator's exercise of discretion. Assume that the treating physician finds a participant to be disabled but the consulting physician does not. Assume further that although there is some evidence to support the plan administrator's decision, a court would find under *de novo* review that the evidence weighs more in favor of the participant than the plan administrator. Finally, assume that the plan grants discretion to the plan administrator to make the determination. Normally, the court would affirm the plan administrator's decision, even though the court might disagree with the plan administrator's decision, because the decision has a reasonable basis in the evidence. However, under the reasoning of the Ninth Circuit, the plan administrator would have to overcome the "special weight" given to the treating physician's opinion. Further, because the court would be of the opinion that the reasons proffered by the plan administrator were insufficient, the court would find that a conflict of interest exists and would therefore use the *de novo* standard of review. Under that standard, the court would rule against the plan administrator. Thus, deferential review would no longer exist because the court would find that the plan administrator's reasons were "insufficient" because the plan administrator has not overcome the presumption in favor of the treating physician's opinion.

Although it is not clear what quantum of evidence is insufficient, perhaps the Ninth Circuit means those cases where evidence that supports the plan administrator's decision is wholly absent or is so "insufficient" as to be no more than a "scintilla of evidence." *Nord*, 296 F.3d at 832.

However, if the evidence is so deficient that it would not meet this standard, such a determination would be held to be arbitrary and capricious even under a deferential standard of review. Therefore, unless the Ninth Circuit is imposing a higher burden on the plan administrator than merely providing some evidence in support of the plan administrator's decision, couching the treating physician rule in conflict of interest terms makes no sense.

The Ninth Circuit's use of the treating physician rule in both this case and in the *Regula* case indicates that the Ninth Circuit is using the rule to alter the traditional deference given to a discretionary decision made by the plan administrator rather than as simply another method of analyzing conflicts of interest. In the case below, the Ninth Circuit noted that the plan used a consulting physician that disagreed with the determination made by the treating physicians. Although the Ninth Circuit referred to this evidence as a "scintilla of evidence," *Nord*, 296 F.3d at 832, it seems reasonably clear that the Ninth Circuit was not merely requiring that the plan have some reasonable evidentiary basis for its decision, but instead was requiring the plan to overcome a presumption in favor of the treating physician. This is so because under deferential review, the fact that contrary evidence exists does not make a decision arbitrary and capricious. *E.g., Oldenburger v. Central States, S.E. & S.W. Areas Pension Fund*, 934 F.2d 171, 173-74 (8th Cir. 1991). In sum, although a plan administrator must consider all evidence regarding a claim, including the opinion of a treating physician, the treating physician's opinion is not entitled to "special weight" and the plan administrator's decision must be upheld under deferential review as long as there is a reasonable basis in the evidence for the decision. Similarly, the treating physician rule cannot be used as a basis for finding a conflict of interest warranting *de novo* review.



## CONCLUSION

For the reasons stated, the Court should hold that the Ninth Circuit erred in its determination that the treating physician rule applies with respect to ERISA benefit decisions.

Respectfully submitted,

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